Communicable Disease UPDATE

Newsletter of the Bureau of Communicable Disease Control, Massachusetts Department of Public Health Vol. 6, No. 2 Spring 1998

Herpes strikes 1 in 5

One in five Americans has genital herpes infection, and the number of people living with this incurable sexually transmitted disease has increased 30% since the late 1970s, according to the Centers for Disease Control and Prevention (CDC).

The findings were reported in the October 16, 1997 *New England Journal of Medicine.* The CDC estimates that nearly 22% of the population overall (45 million Americans), and almost 45% of African-Americans are infected with herpes simplex virus type 2 (HSV-2). The study also found that HSV-2 is more common among women (approximately one out of four women) than men (almost one out of five). This may be related to the higher efficiency of transmission from men to women. Since the last national survey of HSV-2 prevalence (conducted between 1976 and 1980), prevalence has increased most dramatically among young white teens. HSV-2 prevalence among 12 to 19-year-old whites is now five times higher than it was in the late 1970s; young people aged 20-29 years are now twice as likely to have HSV-2.

HSV-2 is usually transmitted sexually and causes recurrent painful ulcers in adults and severe infections in infants. Herpes can also be severe in people with suppressed immune systems. Symptoms of herpes can be treated, but the disease cannot be cured. With or without visible symptoms, the disease can be transmitted between sex partners. Herpes may play a major role in the heterosexual spread of HIV in this country. Herpes can make people more susceptible to HIV infection and make HIV-infected individuals more infectious. Preventing herpes can help control both epidemics.

Herpes is believed to be most infectious when sores and blisters are present. It is best to abstain from sex or direct contact when these symptoms are present. Between symptom outbreaks or with a partner whose herpes status is unknown, the consistent and correct

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Meningococcal vaccination policy

Meningococcal vaccine is not recommended for routine use due to its ineffectiveness in children under 2 years of age, its relatively short duration of protection, and its failure to eliminate carriage of the bacteria which cause the illness. The vaccine also does not provide protection against all strains of the bacteria that cause illness. *Large-scale use of meningococcal vaccine is only recommended for controlling outbreaks when they occur, only in communities in which they occur, and not on a universal basis (MMWR 1997:46 No. RR-5).* See page 2 for definition of an outbreak.

Effective February 23, 1998, the Rhode Island Department of Health (RIDOH) announced a change in policy for the use of meningococcal vaccine. The new policy ***does not*** follow the Advisory Committee on Immunization Practices (ACIP) and the Centers for Disease Control and Prevention (CDC) recommendations (see page 2). The RIDOH recommends that residents age 2 through 22 years receive meningococcal vaccine. **The Massachusetts Department of Public Health (MDPH) continues to follow the ACIP and CDC recommendations and therefore *is not recommending or providing meningococcal vaccine*** for residents of Massachusetts.

Surveillance for meningococcal illness is ongoing in Massachusetts, with a high priority placed on identifying potential outbreaks. No outbreaks of disease have been identified in Massachusetts, and the number of reported cases remains stable (50-100 per year). Thus far, this year there have been fewer reported cases than last year and no clusters of cases. As recommended by the ACIP, each case is followed up with prompt identification and chemoprophylaxis of close contacts. Meningococcal disease is treatable and curable with antibiotics and, treated early, most patients recover fully.

Questions regarding the MDPH meningococcal vaccination policy may be directed to the Epidemiology Program at (617) 983-6800.

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Inside

Epidemiology

Rabies reminder

April was Rabies Awareness Month. The Massachusetts Department of Public Health wants to remind people across Massachusetts that rabies is still very much a problem in nearly all cities and towns. Recently, a rabid puppy exposed over 60 children and adults, costing nearly $100,000 in post-exposure prophylaxis. Incidents like this can be avoided through proper pet vaccination and a strict adherence to pet quarantine regulations. Boards of health and others are encouraged to sponsor educational and awareness activities on a local level.

A related rabies update: please note that the Massachusetts Division of Fisheries and Wildlife is responsible for all **ferret** quarantines. After a bite, scratch, or other mucous membrane exposure of a human or animal, ferrets must be quarantined for ten days. The Division of Fisheries and Wildlife can be reached at (617) 727-3151, x 327.

Meningococcal vaccination policy

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The ACIP and CDC recommend the use of meningococcal vaccine for:

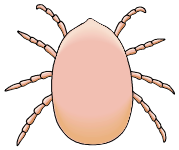
1. travelers to countries with endemic meningococcal disease, and
2. individuals with certain medical conditions that place them at high risk.
3. Vaccination may also be indicated if an institution- or community-based outbreak of meningococcal disease is identified.

How is an "outbreak" of meningococcal disease defined? A community- or organization-based "outbreak" of meningococcal disease is defined as the occurrence of three or more cases of confirmed or probable meningococcal disease due to a common serogroup of *Neisseria meningitidis* during a period of three months or less among persons residing in the same area, or with a common affiliation, with a primary attack rate of at least 10 cases per 100,000 population.

You may access the ACIP recommendations through the CDC web site at: <http://www.cdc.gov/epo/mmwr/preview/ind97_rr.html>. Select the *MMWR* volume for February 14, 1997 (Vol.46/No. RR-5).

Lyme Disease advisory committee

As Lyme disease cases continue to increase in Massachusetts, the need for public education, improved surveillance, and effective policy becomes greater. To help the Massachusetts Department of Public Health (MDPH) improve its efforts in preventing Lyme disease, the MDPH is announcing the formation of a statewide Lyme Disease Advisory Committee. The purpose of the committee will be to advise MDPH on



matters related to Lyme disease, including policy, surveillance, and education. Members of this committee will be selected from nominees by the MDPH. Members will serve for a period of two years. Nominations are encouraged from the following categories: citizens' groups, government service, legislators, health providers' associations, health officers' groups, and technical and academic fields. Although attendance at quarterly Committee meetings will be open to all, to ensure the most diverse representation, membership on the Committee will be limited to one official individual (officer, board member, etc.) per agency, group, association, or institution represented.

To obtain a membership nomination form, call (617) 983-6800. Mail the completed nomination form to Alfred DeMaria, Jr., M.D., State Epidemiologist, Assistant Commissioner, Bureau of Communicable Disease Control, Massachusetts Department of Public Health, 305 South Street, Jamaica Plain, MA 02130; or fax the completed form to Dr. DeMaria at (617) 983-6925. Although nomination forms should be submitted by May 1 for the formation of the initial committee, nominations will be accepted at any time.

New needlestick hotline

A new national hotline (staffed by physicians) was created in November 1997 to help counsel clinicians in treating health care workers with job-related exposure to blood-borne diseases and infections. By calling **(888) 448-4911** from anywhere in the U.S., 24 hours a day, clinicians can gain access to the National Clinicians' Post-Exposure Prophylaxis Hotline, also called the PEPline.

1997 highlights

Last year was a year of accomplishment and challenge for the Division of STD Prevention (DSTDP). Compared to 1996, there was a 29% decline in infectious syphilis (from 262 to 187 cases); a 4% decline in gonorrhea (from 2,163 to 2,077 cases); and an increase of 8% in chlamydia (from 6,791 to 7,330). The increase in chlamydia is attributed to the first full year of using the more sensitive ligase chain reaction (LCR) test, and broader screening activities.

The Division also established new contracts for prevention services, thereby increasing the availability and accessibility of high-quality STD care and knowledge. These prevention services are provided through certain clinics that feature community outreach, as well as an expansion of satellite services with other providers. Thus, the goals of expanding the network of services and education, and moving STD prevention services from the clinics to the communities, are beginning to be realized.

We also received three new grants. One expands capacity to conduct surveillance in jails. A second allows expanded screening services in jails. The third allows us to measure and improve the quality of surveillance within managed care organizations. As managed care becomes the dominant form of medical service coverage in the nation, this grant is particularly significant. It places the Division in the forefront of efforts of looking at how public health and managed care can work together. Finally, DSTDP remains in the forefront of clinician education service and research as it continues to be the home of the New England STD/HIV Prevention Training Center, one of ten regionally-based centers funded by the CDC, providing STD prevention education to clinicians and laboratorians throughout New England.

Herpes

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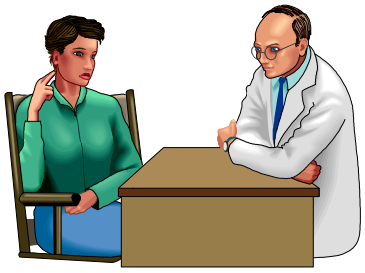
use of latex condoms is the best protection. For people with frequent or severe outbreaks of herpes, antiviral medications may help to relieve or suppress outbreaks.

CDC is now working with other public health experts to develop a national plan which will specifically address the prevention of herpes. This will be part of a larger effort to begin to address the problems posed by viral STDs. The plan will address development of comprehensive national prevention guidelines, outline enhanced monitoring of levels of herpes infection, and propose new educational activities for health care professionals and the general public.

Who talks about STDs?

At current rates, at least one in four–and perhaps as many as one in two–Americans are expected to get a sexually transmitted disease or STD in their lifetime. According to a new survey by the Kaiser Family Foundation reported in *Glamour* magazine, many women may not be adequately screened for even the most common STDs. Only one out of eight women (12%) between the ages of 18-44 years reported that a health provider had raised the subject of STDs, other than HIV/AIDS, as part of their routine reproductive health care. Just 3% brought up STDs themselves. Most women (64%) said it is up to the health professional to initiate these conversations. While few of the women surveyed did talk about STDs at their first visit, 83% said, in general, STDs *should* be discussed when seeing a new health care provider for gynecological care.



Conversations about STDs were much less likely to be initiated by either provider or patient than other important health topics, such as breast self-exam, pap smears, and birth control. Many of the women who did not have a conversation about STDs during their gynecological or obstetrical visit reported that they were not asked, nor had they otherwise provided their health professional with other critical information that are part of assessment of patient's risk, such as whether they were currently sexually active, in a monogamous relationship, or using condoms regularly. Providers also failed to ask information about how many sexual partners their patients had in the last year, or questions about oral or anal sex. Despite this, 80% of these women who did not discuss STDs thought their health provider had enough information to assess the women's individual risks.

Last year, the Institute of Medicine released its report on STDs in America and called it the nation's "hidden epidemic." A major contributing cause is lack of adequate social/sexual history-taking during a medical office visit. Without such history-taking, assessment of a person's risk for an STD is left to assumption, bias, and other sources of information. Lack of an accurate assessment of risk eliminated the possibility of a preventive impact on risk behavior. The Division of STD Prevention is offering a half-day course to help clinicians improve their social/sexual history-taking skills. Call (617) 983-6940, or write to Paul Etkind, Director, Division of STD Prevention, for details.

Confidentially speaking

Miss H. is a 22-year-old woman born outside the United States. She has lived in Boston for one year and is a student. She regularly attends religious services and is active in her community. However, Miss H. is a very private and reserved woman, and when she was diagnosed with smear positive pulmonary tuberculosis, maintenance of confidentiality was of the utmost importance to her.

It is determined that Miss H. has been infectious for several weeks, and a contact investigation with TB screening/skin testing is planned by the local public health nurse. The screening will involve family members and household contacts, most of whom know Miss H's diagnosis. However, school, church, and work contacts also need to be screened, and this causes the patient much distress. The public health nurse and outreach educator both try to reassure the patient that only close contacts, people with whom the patient spent considerable time and who are identified by the client, will be contacted to arrange TB skin testing. Unfortunately, the public health staff learns that the school attended by the client has a policy that all classmates in every class be notified of their exposure to TB. Additionally, since the patient also participated in her church's day care program during services, and the church has a policy that parents be notified of any possibility of exposure to any communicable disease, a letter is being sent to parents of all enrolled children.

In a small, close-knit community, any descriptive information can identify a patient. Facts such as school, place of work, or religious affiliation, can be used to deduce identity. Additionally, TB is often associated with death, poverty, disgrace within the community, or within American society. Thus, the development of specific strategies designed to minimize the spread of information is essential.

Clearly, public health professionals have a responsibility to assure the health and safety of the community, and need to work with organizations and institutions, as well as other health professionals, to accomplish this goal. They also have a responsibility to protect the client's anonymity. Often there is real or potential conflict between the needs of the client and the institutional policy/procedure. Negotiating a resolution takes skill, patience, and a great deal of knowledge.

Public health staff must work quickly to control overreaction on the part of institutions/organizations. An intervention plan must include education of involved personnel and explanation of real (as opposed to perceived) risk of contagion. Above all, public health staff must continually reinforce the need to maintain the client's confidence. Sensitivity to the impact of disease in a specific culture or community is essential. Communication among involved parties, especially policy makers in organizations, must be maintained. Helping policy makers rethink institutional procedures that are not based in science is a prime role of the public health professional.

If a patient perceives that their confidence has been violated or threatened, the long term relationship between the client and health care professionals may be jeopardized, putting therapy completion at risk. The tension faced by public health staff as the needs and rights of the individual are balanced against the protection of the public's health is fairly constant. The consequences of failing to recognize this tension are significant. Knowledge, understanding, negotiation skills, and communication skills all are essential tools for the public health staff.

Communicable Disease Updates: 1996 vs. 1997 Reported Cases

DISEASE	1996	1997*	% change from 1996
AIDS	1,240	804	-35%
Botulism	0	0	–
Campylobacter	1,469	1,474	+.3%
Chlamydia	6,791	7,330	+8%
Cryptosporidiosis	83	58	-30%
E. coli O157:H7	162	99	-39%
Giardiasis	979	894	-9%
Gonorrhea	2,163	2,077	-4%
Hepatitis A	251	253	+.8%
Hepatitis B (acute)	113	72	-36%
Lyme Disease	378	364	-4%

* Preliminary data. Reporting not yet complete.

DISEASE	1996	1997*	% change from 1996
Measles	12	16	+33%
Invasive Meningococcal Disease (Neisseria)	70	93	+33%
Pertussis	1,236	573	-54%
Rabies (animal)	115	282	+145%
Rubella	21	1	-95%
CRS**	0	0	–
Salmonellosis	1,638	1,259	-23%
S. typhi (Typhoid)	18	19	+6%
Shigellosis	264	316	+20%
Syphilis (early)	262	187	-29%
TB	262	268	+2%

** Congenital Rubella Syndrome

You be the epi

A Boston pediatrician contacts the Massachusetts Immunization Program (MIP) to consult on a febrile rash illness in a 14-month-old girl he recently vaccinated. He is concerned because she is an adoptee from China who arrived in the U.S. only 10 days ago. The physician first saw her one week earlier, when she presented with a runny nose, a fever of 101°F, and no additional symptoms. The physician saw her six days later and administered MMR, OPV, and DTaP-Hib. One day post-vaccination, she developed a rash on her face and an increasing fever. Two days post-vaccination, she developed a fever of 104°F, diarrhea, conjunctivitis, a runny nose, a dry cough, and the rash, that began on her face, had spread over her entire body.

The physician thinks she is infectious; his office is full of infants, small children, and some pregnant women. What do you tell the pediatrician to do, and what other steps should you take to investigate and control the spread of this illness?

Analysis

Onset of rash one day post-vaccination is unlikely to be due to the vaccination. The rash, high fever, conjunctivitis, and respiratory symptoms are highly suggestive of measles; rubella is also a possibility. Because the patient received MMR around the time of rash onset, serologic confirmation of measles or rubella will not be possible. Proceed on the presumption that this is a case of measles, which requires an immediate response.

Step 1

Collect from staff at the doctor's office information on demographics, symptoms, immunization history, and source of infection. Arrange for the pediatrician to collect a urine or nasopharyngeal specimen for viral isolation within five days of rash onset and to send it to the State Laboratory Institute.

Step 2

Implement control measures as outlined in the 1997 MIP measles control guidelines. Determine the infectious period of the patient. (The infectious period for measles is four days before through four days after rash onset, counting the day of onset as day zero.) Have the staff at the doctor's office:

a) identify all individuals exposed to the patient (including being in the same room up to two hours after she was present) during the two visits she made while infectious; of these, identify susceptibles, including high-risk ones (see MIP control guidelines for definitions);

b) immunize susceptibles with MMR, preferably within 72 hours of exposure, which can prevent measles in exposed people;

c) administer immune globulin (IG) intramuscularly to susceptibles with contraindications to measles vaccine, including infants, if within six days of exposure;

d) refer any exposed pregnant women to their health care provider.

Step 3

Notify the local board of health and relay all information collected so far. Call the girl's family and ask about the immune status and risk status of the household members. Have susceptible members vaccinated or be given IG, as appropriate. Ask about what other individuals or establishments may have been exposed during the girl's infectious period. Tell the parents to keep the girl at home without visitors for the rest of her infectious period. Confirm the travel dates of the girl and whether the likely site of infection was China.

Step 4

Enlist the help of the local board of health in following up in similar fashion with the exposed individuals or establishments identified by the family.

Note: For more complete information, consult the 1997 *Red Book* and the MIP's 1997 Measles Control Guidelines. For copies of the MIP Disease Control Guidelines, call (617) 983-6800.

Influenza and pneumococcal vaccine for children

The Massachusetts Immunization Program (MIP) wants to remind pediatric providers that influenza and pneumococcal vaccines are available at no charge for all high risk children in the state. Please contact your vaccine distributor to order adequate supplies for your high risk patients.

Influenza vaccine, available in the early fall, must be ordered during the early summer. Please look for a mailing regarding flu vaccine orders for the 1998-99 influenza season in June, and be sure to place an order for flu vaccine for your high risk children before August 1. Pneumococcal vaccine for high risk patients is available year-round. If you are unsure of the "high risk" categories, or if you have any other questions, please call your regional MIP office or the Immunization Program at (617) 983-6800.

Immunization

Varicella Requirement

Varicella vaccine is currently recommended as part of the routine childhood immunization schedule by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP). Beginning on August 1, 1998, varicella vaccine will be required by the Office for Childcare Services for some children attending day care centers.

There is a place on our revised *Certificate of Immunization* for health care providers to document a reliable history of varicella disease. If you are using older certificates or "Blue Books," chicken pox history may be recorded in the space for varicella vaccine or other vaccines.

About 4 million cases of varicella occur every year in the United States. The Centers for Disease Control and Prevention (CDC) estimate that varicella infections result in up to 15,000 hospitalizations and over 100 deaths and 25-40 cases of congenital varicella syndrome per year. Other complications include pneumonia, acute cerebellar ataxia and serious skin infections. One of these serious skin infections, group A streptococcal infection (GAS), appears to be increasing as a complication.

Varicella has a high mortality rate (10-30%) in high risk children and adults. Vulnerable high risk individuals who cannot be immunized must rely on those around them to protect them from disease exposures through community-wide broad based coverage.

Varicella vaccine is safe, effective and widely used. Since being licensed in 1995, over 7 million doses have been distributed nationwide, with over 80,000 doses in Massachusetts. Recent studies in the United States show the vaccine is protective for up to 10 years, with studies in Japan showing protection for up to 20 years. The vaccine protects about 80% of recipients from acquiring any disease at all, and an additional 20% of recipients experience a very mild form of varicella, with few symptoms and less than 50 lesions.

In addition to preschool children, state-supplied varicella vaccine is now available for all children and adolescents through age 18 years.

New Day Care Immunization Requirement*

One dose of varicella vaccine, (or physician certified reliable history of chickenpox), will be *required* for all children attending day care who are 19 months of age or older and who were born on or after January 1, 1997.

*While not required, varicella vaccine is strongly *recommended* for susceptible preschool children.

Rubella outbreak hits northeast

An outbreak of rubella in adults has been reported in Connecticut and New York. The cases are occurring primarily among Latin American immigrants. As of February 24, 1998, 48 confirmed cases have been reported in connection with the outbreak. This is a significant number, given that only 238 and 161 cases were reported nationally in 1996 and 1997, respectively. In response, health officials in Connecticut and New York have begun immunization drives aimed at adults from Central and South America.

The current outbreak in Connecticut and New York is reminiscent of the 1993-1994 rubella outbreak in Massachusetts, in which 131 cases were reported, overwhelmingly in adults. More than one-third of the cases occurred in Latin Americans. Seven cases occurred in pregnant women, and one case of congenital rubella syndrome was identified, the first known case of CRS in the state since 1979. Almost half of the total cases involved institutions and hard-to-reach populations, such as the homeless, substance abusers, and those in correctional and other residential settings.

Studies have shown than many children and adults from other countries are susceptible to rubella. Many U.S.-born young adults also have never received rubella vaccine.

Given the very real potential for rubella to spread from Connecticut or New York to Massachusetts, and the continuing problem of underimmunization of adults, the Massachusetts Immunization Program (MIP) is making two precautionary recommendations:

1. Health care providers should be alert to all cases of febrile rash illness without other apparent cause and report them immediately to their local board of health and the MIP **(617-983-6800)**.

2. Health care providers, as well as directors of large institutions where either clients or staff are unlikely to be fully immunized, should arrange to get as many susceptible individuals as possible vaccinated with MMR. **Given the threat of another outbreak, the MIP will provide MMR without charge for this purpose.** If you would like to obtain MMR vaccine, please contact your local vaccine distributor or your regional immunization office.

Western and Central regional update

Tuberculosis Surveillance Area (TSA) 1

The Division of TB Prevention and Control has adopted new area boundaries. The Blackstone Valley communities are now part of TSA 1.

Epidemiology: In 1997 there were 36 cases (13.4%) verified for TSA 1. Analysis of the cases in TSA 1 by county indicate that 17 (47.2%) were from Worcester County, and 15 cases (41.7%) were from Hampden. The remaining 4 cases were from Berkshire, Hampshire, and Middlesex counties.

Clinical Services: Free clinic services are provided at Baystate Medical Center, Springfield; Berkshire Medical Center, Pittsfield; Health Alliance, Burbank Campus, Fitchburg; Franklin Medical Center, Greenfield; Harrington Memorial Hospital, Southbridge; Holyoke Hospital, Holyoke; Getchell/Ward Clinic, Family Health and Social Services, Worcester (in the former Worcester City Hospital).

Support Services are provided by Carol Cahill, RN (TSA Nurse), who can be reached at (413) 586-7525, or from the (413) area at (800) 445-1255, Evelyn Thomas (Administrative Assistant), and Kathleen Lupien (Case Register Surveyor). The TSA 1 office is located at the Department of Public Health's Western MA Regional Office in Northampton.

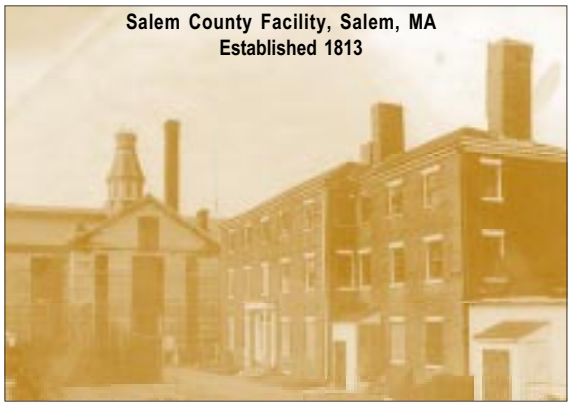
Community Outreach: Walezka (Wally) Rivera covers the Central Region, and Evelyn Rodriguez covers the Western Region. They are fluent in Spanish and English. Outreach staff can be reached at (413) 586-7525.

The corrections collaborative for TB prevention

Tuberculosis (TB) prevention in state and county correctional facilities is an important communicable disease control activity. In order to strengthen TB prevention activities, collaborations are ongoing between the Division of Tuberculosis Prevention and Control and state and county correctional facilities.

A series of correctional health care meetings were held to provide a mechanism of communication between the Division of TB Prevention and Control and correctional facilities, with goals of updating screening and treatment procedures, and improving adherence to TB preventive therapy. The County Health Care Administrators Group meets on a regular basis to review health care issues of concern in county correctional facilities. This group participated in the development of a comprehensive TB policy for use by long-term and short-term correctional facilities. They have also been instrumental in making recommendations for delivery of TB prevention services and for appropriate inmate educational materials. As a result, there have been several important advances toward better TB prevention in correctional facilities.

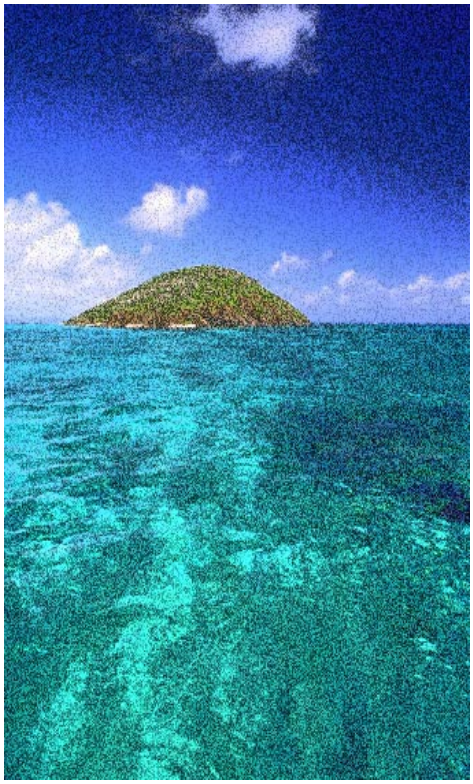
A TB curriculum has been developed which is linguistically and culturally appropriate to the inmate population. The curriculum consists of a bilingual (English and Spanish) flip chart with accompanying text, overheads and slides, and an easy-to-read pamphlet. Both provide information about TB transmission and pathogenesis, symptoms, risk factors and high risk groups, preventive and curative therapies, BCG, the TB/HIV connection, the importance of adherence to therapy, and instruction regarding the continuation of preventive therapy upon release.


Salem County Facility, Salem, MA
Established 1813

A County Collaborative: the County Inmate TB Preventive Therapy (CITPT) project is being piloted, in collaboration with two county correctional facilities, to improve adherence to preventive therapy among county inmates within the facility and upon release. The CITPT project will be housed at the Suffolk County House of Correction in Boston, an urban facility, and the Plymouth County Correctional Facility in Plymouth, a more rural facility. Inmates at participating facilities who are placed on TB preventive therapy, are referred to the Corrections Project. Upon release, consenting inmates who have yet to complete their course of preventive therapy, will be given a TB clinic appointment and will be assigned for follow-up by their local Board of Health and by a TB Outreach Worker.

For questions regarding TB prevention in Massachusetts correctional facilities, please call Marilyn DelValle, Corrections Coordinator, Division of Tuberculosis Prevention and Control, at (781) 828-7090.

CD UPDATE
State Laboratory Institute
305 South Street
Boston, MA 02130



Traveling?

International travel information is now available, toll-free, via the Centers for Disease Control and Prevention (CDC), 24 hours/day at **(888) 232-3228**. The information can be faxed and can also be found on the Internet at <http://www.cdc.gov/travel>. Travel questions can also be directed to the Logan International Health Clinic at **(617) 568-4878**.

Save the dates

Massachusetts Public Health Association Sponsored Events

Cancer Survivorship: A Journey to Healing
May 13 in Boston (part of the Women's Health Breakfast Series)

Public Health Nursing Conference
May 15 in Marlboro

Elder Care in a Changing World
May 19 in Holyoke

Contact MPHA at (617) 524-6696 for more information or registration.

CDC Satellite Training Course

Adult Vaccine Preventable Diseases
June 4, 1998. To be held at the State Laboratory Institute in Jamaica Plain. Accessible by MBTA. Parking only at Fitz-In Lot at 3649 Washington Street. This program will be carried live by the Health and Sciences Television Network (HTSN), which broadcasts to 1300 nationwide downlink sites, mostly in acute care hospitals and educational settings. It will also be carried live by the Long Term Care Network (LTCN). For more information to downlink your site or attend the program, please call Jean Franzini, RN from the Division of Epidemiology and Immunization at (617) 983-6850.

Third Annual Conference of the Massachusetts Immunization Action Partnership (MIAP)

May 28, 1998, 8:30 AM–4:30 PM. To be held at the Crowne Plaza Hotel in Worcester. Registration fee is $25. The keynote speaker is William Atkinson, MD, MPH, of the National Immunization Program, CDC, Atlanta, GA. CME/CMU credits have been applied for. For more information please contact Mimi Larzelere at MIAP, c/o The Medical Foundation, (617) 451-0049, ext. *870 or fax (617) 451-0062.

FDA Satellite Training Courses

Food Microbiological Control
August 11-13, 1998, 11:30 AM– 4:00 PM (3-day course). To be held at the State Laboratory Institute in Jamaica Plain. For more information call Beth Altman from the Division of Food and Drugs at (617) 983-6769.

Foodborne Epidemiological Investigations
September 15-18, 1998, 11:30 AM–4:00 PM (4-day course). To be held at the State Laboratory Institute in Jamaica Plain. For more information call Allison Hackbarth, MPH from the Division of Epidemiology and Immunization at (617) 983-6800.

Both courses were developed as part of the National Food Safety Initiative.

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